qualified relative, as defined in section 9001 of title 5, United States Code.

Enrollee means an eligible individual whose application for coverage the Carrier has approved and whose coverage is in effect.

FLTCIP means the Federal Long Term Care Insurance Program.

Free look means that within 30 days after you receive the Benefit Booklet, you may cancel your coverage if you are not satisfied with it and receive a refund of any premium you paid. It will be as if the coverage was never issued.

Full underwriting is the more comprehensive type of underwriting under the FLTCIP, which requires that you answer many questions about your health status to enable the Carrier to determine whether your application for coverage will be approved. The Carrier may also require review of your medical records, a phone interview, or an in-home interview.

Stepparent means any person, other than your mother or father, who is currently married to one of your parents, or, if one of your parents is dead, a person who was married to that parent at the time of that parent's death.

Underwriting requirements means the information about your current health status and history and other information that you must provide to the Carrier with your application for coverage to enable the Carrier to determine your insurability.

Workforce member means a Federal civilian or Postal employee, member of the uniformed services, Federal annuitant, retired member of the uniformed services, or member of any other eligible group, as defined in section 9001 of title 5, United States Code. An active workforce member is one who is currently employed or is on active duty.

[68 FR 5534, Feb. 4, 2003, as amended at 70 FR 30606, May 27, 2005]

§ 875.102 Where do I send benefit claims?

You must submit your benefit claims to the FLTCIP Carrier or its designee.

§ 875.103 Do I need to authorize release of my medical records when I file a claim?

Yes, if you file a claim for benefits, the Carrier needs to have a valid authorization from you to release your medical records.

§ 875.104 What are the steps required to resolve a dispute involving benefit eligibility or payment of a claim?

(a) If you dispute the Carrier's denial of your eligibility for benefits or your claim for payment of benefits, you must first send a written request for reconsideration to the Carrier no later than 60 days from the date of its decision.

(b) The Carrier must provide you with written notice of its review decision no later than 60 days after the date it receives your reconsideration request.

(c) If the Carrier upholds its denial (or does not respond within 60 days), you have the right to appeal its reconsideration decision directly to the Carrier. You must make this appeal in writing within 60 days from the date of the Carrier's notice upholding its decision. You will be notified of the decision on your appeal in writing no later than 60 days from receipt of your appeal request.

(d) If a denial of your eligibility for benefits or a denial of your claim is upheld upon appeal due to the evaluation of your medical condition/functional capacity, the Carrier will inform you that you may request that an independent third party, mutually agreed to by OPM and the Carrier, review the decision. You must make this request in writing within 60 days from the date of the notice informing you of the appeal decision. The independent third party must notify you in writing of its decision no later than 60 days from the Carrier's or its designee's receipt of your request for appeal to the third party. This is the final administrative remedy available to you. The decision of the independent third party is final and binding on the Carrier.

(e) You may seek judicial review of the final administrative denial of a claim. Such action may not be brought prior to exhaustion of the administrative process provided in this section. To pursue such judicial review, you must bring legal action against the Carrier in an appropriate United States district court within 2 years from the